University of Massachusetts Lowell
Learning with Purpose

University Crossing
220 Pawtucket Street, Suite 300
Lowell, Massachusetts 01854
Tel. 978.934.6800
Email: Disability@uml.edu

DISABILITY SERVICES

Disability Verification Form for Medical and Psychological Conditions and Attention-Deficit/Hyperactivity Disorder

The student below has applied for accommodations from Disability Services (DS) at UMass Lowell. To determine eligibility and to provide services, we require documentation of the student's disability(ies).

Under the Americans with Disabilities Act as amended and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To be covered under the law, documentation must establish a specific disability and that one or more major life area is substantially limited. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

The information below must be provided by a licensed professional with a history of an established relationship with the student and who is qualified to support this need. *As deemed most appropriate, students may choose to have one provider complete this form or have it completed by multiple providers.*

After completing and signing this form, please send it directly to the student or our office via the letterhead information. This form will remain in the student's confidential Disability Services file and is not tied to educational records. Additionally, please attach any other relevant documentation. Please contact us if you have questions or concerns. Thank you for your assistance.

RELEASE OF INFORMATION

I, _____, hereby authorize the release of the following information to the Disability Services office at UMass Lowell for the purpose of determining my eligibility for academic accommodations.

The provider will verify an established disability for the following categories:

- Attention Deficit Hyperactivity Disorder: ☐Yes ☐No
- Psychological Disability: ☐Yes ☐No
- Medical Condition/Disability: ☐Yes ☐No

Disability Services may need to contact this provider if more information is needed and will alert me in writing in the event this is necessary. If no consent is given, I understand this *may* delay my access to accommodations. Please initial below:

____ I hereby give consent for Disability Services to contact this provider for 1 year from the date below to discuss my condition(s) and needs. I understand that I may revoke this consent at any time by providing written notification to Disability Services, except to the extent that this consent has already been relied upon.

Student ID #: _____

Date: _____

Signature: _____

TO BE FULLY COMPLETED BY LICENSED PROVIDER (FOR ALL CATEGORIES)

Student's Name: _____ DoB: _____

Please list the student's diagnosis(es) and dates diagnosed (i.e. Type 1 Diabetes, 7/2001 and/or Generalized Anxiety Disorder (GAD) DSM-5 300.02 (F41.1), 1/2017): _____

_____

_____

If an ADHD Diagnosis, state diagnosis and date diagnosed above and check the predominant presentation:

☐ Combined Inattentive and Hyperactive-Impulsive Presentation
☐ Predominantly Inattentive Presentation
☐ Predominantly Hyperactive-Impulsive Presentation

Do you confirm that you have a history of an established relationship with the student listed above and are qualified to report on behalf of the student's diagnosis(es): ☐**Yes** ☐**No**

Date of most recent contact with student: _____. Is the student currently under your care? ☐**Yes** ☐**No**

Major Life Activities Assessment.

Please check which of the following major life activities listed below are affected because of the diagnosis(es). Please indicate the severity of limitations.

Life Activity	**No Impact**	**Minor Impact**	**Moderate Impact**	**Substantial Impact**
Caring for oneself	☐	☐	☐	☐
Talking	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Breathing	☐	☐	☐	☐
Seeing	☐	☐	☐	☐
Walking/Standing	☐	☐	☐	☐
Interacting Socially	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Performing physical tasks	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Working a job	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Writing/Spelling	☐	☐	☐	☐
Calculating	☐	☐	☐	☐
Memorizing	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Listening	☐	☐	☐	☐
Other:	☐	☐	☐	☐

Please provide more information on any functional impact noted above specific to an academic setting (e.g., unable to type for more than ten minutes or unable to walk more than 50 feet without fatigue, etc.)?

_____

_____

_____

Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

Medication prescribed? ☐**Yes** ☐ **No** If yes, by whom? _____

If yes, please list: _____

Medication effect on academic functioning and side effects:

Do limitations/symptoms persist even with medications? ☐**Yes** ☐ **No**

In the past year, has the student been hospitalized/missed significant class or workdays in relation to the above diagnosis(es)? ☐**Yes** ☐ **No**

If yes, please share relevant information: _____

How long do you anticipate the student's academic achievement will be impacted by each diagnosis(es)? Please distinguish if there are differing durations. (i.e. less than six months, up to one year, lifelong/chronic)

What other factors might affect the student's academic performance (i.e. medical treatment or symptoms)?

Recommendations of academic supports at UML (regarding classroom, home study, and testing environments):

To best assist the student, please attach any relevant additional information you have regarding the diagnosis(es), i.e. medical/behavioral health records, neuropsychological testing, and/or academic concerns.

Thank you for your help in providing this information so that we may begin providing services as soon as possible. Please return this form to the contact information shown on the letterhead or directly to the student.

LICENSED PROVIDER INFORMATION*
(Please sign and date below and fill in all other fields completely using PRINT or TYPE)

Provider's Name & Credentials: _____ License No. _____

Field of Practice: _____ Address: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

**Examples of qualified professionals are licensed psychologists, psychiatrists, neurologists, licensed mental health providers, PCPs or NPs with knowledge of functional limitations. The diagnosing professional must have expertise in the differential diagnosis of the documented psychological diagnosis(es) or condition and follow established practices in the field.*